Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Consultants in Pain Medicine

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-0559-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the Texas Mutual explanation of benefits, our claim is being denied because the submitted documentation does not support the service being billed and the payer deems the information submitted does not support this level of service. We content that per the 2014 American Medical Association (AMA) Current Procedural Terminology (CPT) Manual, our documentation contains elements that support the 99214 service.

…The 2014 AMA CPT Manual describes 99214 as an Office or other Outpatient visit for the evaluation and management of an established patient, **which requires at least 2 of these 3 key components:**

- **A Detailed History:** The office dictation clearly indicates a detailed history with review of past medical, surgical, family, social, tobacco/alcohol, substance abuse, mental health, communicable disease, current problems, allergies, and current medications.
- **A Detailed Examination:** the dictation further illustrates the detailed exam in with the objective findings of vitals, review of systems, and exam of general, psychiatric, cardiovascular, respiratory, gastrointestinal, sensation, cervical/upper extremities, head and neck, right upper extremity, thoracic/lumbar/sacral, and lower extremities.
- **Medical decision making of moderate complexity:** Lastly, the physician makes a medical decision of moderate complexity with the plan/recommendation of medication, and review of worker's compensation file of approved/denied service."

Amount in Dispute: $128.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 5/9/14. The requestor billed Texas Mutual for an E&M service billed with code 99214. Texas Mutual denied payment because the documentation does not meet the criteria of the code.

1. Texas Mutual agrees the History is comprehensive.
2. The Exam is expanded problem focused since the documentation centered on only the affected body area, right upper extremity, and up to a total of seven additional systems – general, psychiatric, cardio, resp, GI, and skin.

3. The Medical Decision Making is straightforward. The number of diagnoses is one. No points for the amount of data reviewed. The injury was on 12/9/1999. There is only one presenting problem, wrist pain of the right upper extremity. It is chronic and it is table stable. No diagnostics were ordered. The proposed nerve block carries moderate risk.

Code 99214 requires at least a combination of two of these three components – a detailed History, a detailed Exam, and Moderate decision making.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2014	99214	$128.65	$128.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.203 defines the medical fee guidelines for reimbursement of professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-150 – Payer deems the information submitted does not support this level of service.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824.
   - CAC-18 – Exact duplicate claim/service.
   - 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(h).

Issues

1. Did the requestor support the level of service for CPT Code 99214 for each date of service as required by 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient.

   The American Medical Association (AMA) CPT code description for 99214 is:

   > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **A detailed history; A detailed examination; Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. [emphasis added]

The 1995 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99214 are as follows:

- Documentation of the Detailed History:
  - "An *extended* [History of Present Illness (HPI)] consists of at least four elements of the HPI."
  - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient's positive responses and pertinent negatives for two to nine systems to be documented."
  - "A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] must be documented."

  The Guidelines state, "To qualify for a given type of history all three elements … must be met."
- Documentation of a Detailed Examination:
  - A "*detailed examination* …is an extended examination of the affected body area(s) and other symptomatic or related organ system(s)."
- Documentation of Decision Making of Moderate Complexity:
  - *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of treatment recommended are taken into account. Guidelines require that "for a presenting problem with an established diagnosis the record should reflect whether the problem is …inadequately controlled, worsening, or failing to change as expected."
  - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
  - *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk."

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**."

The submitted documentation supports that the requestor provided a review of seven (7) elements of HPI, a review of thirteen (13) systems, and three (3) areas of PFSH. This meets the documentation requirements for a Comprehensive History.

The submitted report shows that the requestor included performance and documentation for a general multi-system exam, which includes 8 or more systems, including constitutional, cardiovascular, respiratory, gastrointestinal, musculoskeletal, skin, neurological, and psychological. This meets the documentation requirements for a Comprehensive Examination.

The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Low Complexity.

Because the documentation indicates that the requestor met at least two (2) of the required key components of CPT Code 99214, this level of service is supported.

2. Procedure code 99214, service date May 9, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.5. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 0.916 is 1.29156. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.816 is 0.0816. The sum of 2.87316 is multiplied by the Division conversion factor of $55.75 for a MAR of $160.18.

   The total allowable reimbursement for the services in dispute is $160.18. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $128.65. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $128.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $128.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.